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Research Paper

Prevalence of Fraud in the Health Insurance Sector: An Overview

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Abstract

The threat of fraud is unbridled across all sectors of the industry, prevalent globally at all levels. The firms have to incur huge costs in fraud detection and prevention. The service industry, similar to the insurance industry, gives financial protection for the risks covered. The main incentive for making easy money and thus committing fraud is the greed for monetary benefits in the form of fraudulent claims or earning higher brokerage for the intermediaries. The Insurance Regulatory & Development Authority of India (IRDAI), interprets the term 'fraud', as "an act of or omission intended to gain dishonest or unlawful advantage". Insurance fraud creates problems for honest policyholders as well as for insurance companies. According to one study, Insurance companies endured a loss of 0% to 15% of their business revenue. As stated by another study, fraudulent health insurance claims have risen to 35% for some insurers. Fraud can be committed by executives within the company, policyholders, or intermediaries. According to the fraud triangle, three components contribute to triggering the risk of fraud: (1) rationalization, (2) incentive, and (3) opportunity. This article aims to study the various kinds of fraud existing in the health insurance sector and the ways to mitigate them. The paper also enquires how fraud impacts the profitability of the insurers; the higher insurance premium for policyholders and the generation of lack of trust between the insured and the insurer due to frauds committed by some people. Discussions have been done regarding the framework given by the regulator for monitoring insurance fraud.

Keywords: claim payments, health insurance, the insurance industry, India, insurance fraud

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Introduction

Fraud is present in every industry whether it is financial, technological, banking, automobile, agriculture, or in the insurance industry. Despite efforts made by professionals, leaders in the industry, and the government in every sector, fraudsters always find loopholes in the system and try to defraud the system for personal and professional gains. In the insurance industry,

there is no tangible product purchased by the insured since it is a service industry. Here, the only thing that matters is the presence of a contract between the insured and the insurer based on the principle of utmost good faith, and hence, the probability of fraud is generally high. In the case of motor insurance where there can be a staged accident, giving wrong information about the circumstances of an accident or the exact date of the accident, boosting a claim or misrepresenting a stolen car, or in health insurance where there can be billing for services not provided, double billing or billing for more expensive service than what was actually received, the list is infinite.

Fraud is disturbing for an insurer's business not only in terms of financial losses but also due to its adverse impact on the reputation and brand of the business. Various costs involved are investigation costs, diligent underwriting costs, filing and fighting lawsuits, and greater cost of investment in a strong fraud-detection system and upgraded technology to survive with the new kinds of fraud in a dynamic environment. The policyholders bear the burden as well in terms of paying higher premiums which is an outcome of the insurance company incurring losses and fighting the fraud in the form of paying false or inflated claims. It can also bring about the loss of cover, a higher rejection rate of claims, write-off of paid premiums, loss of policy benefits and advantages, affecting the credibility of the policyholder and a chance of getting blacklisted, adversely affecting the insurance industry and allied services as a whole.

Literature Review

Insurance frauds are ingrained in the health systems due to the dishonesty of the people concerned (Garcia, 2019). The corruption in these systems affects not only the performance but also the quality and efficiency of the health systems (WHO, 2016). The resources spent on healthcare services in developing economies are fewer compared to the developed economies and therefore health insurance fraud seriously affects developing countries with meagre resources (Wing et al., 2019).

Different countries have devised different interventions to detect health insurance frauds or mitigate them but effective results are elusive due to the complexity of the problem (Abdallah et al., 2016; Wing et al., 2019). There is a dearth of specialization in detecting frauds and therefore at times, the detection is coincidental, leaving it to the regulation of a particular market (Bayerstadler et al., 2016).

Health Insurance Industry and Frauds

On account of the fact that insurance fraud costs the Indian insurance market Rs 45,000 crore in 2019, India lacks an adequate insurance fraud law. In the same year, insurance fraud totalled $100 billion in the United States, $ 4 billion dollars in Australia, $ 3 billion in the United Kingdom, and $ 2 billion to $ 3 billion in other EU nations (Sethi, Business Today, April 5, 2020)

In terms of percentage, most insurers lose around 10% and 15% of their business across all business lines, whereas fraudulent claims in health insurance reached 35%. Insurance fraud rules have been enacted in the majority of developed countries where the insurance sector has evolved (Sethi, Business Today, April 5, 2020)

Annually, the healthcare sector in India loses between Rs. 600 and Rs. 800 crores due to

bogus claims. During the Covid-19 outbreak, insurance fraud has escalated, and investigations have mostly shifted to digital channels (The Hindu Business Line, July 23, 2021).

The Insurance Fraud

Insurance Fraud is a deliberate act by the parties involved in the process to obtain an illegitimate gain that the parties would not have received otherwise. It exploits the insurance contract. According to IRDAI "*Fraud in insurance is an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties*". This could be gained, through:

I. "Misappropriating assets".
II. "Deliberately misrepresenting, concealing, suppressing, or not disclosing one or more material facts relevant to the financial decision, transaction, or perception of the Company's status."
III. "Abusing responsibility, a position of trust, or a fiduciary relationship."

Frauds can occur in different instances such as, by the policyholder at the claims stage, disclosing facts either by the insurer or the insured or by agents for extra commission.

Fraud influences the lives of countless individuals as well as the insurance sector. Insurance frauds have been there since the insurance industry's inception as a commercial enterprise. But in recent times, it was noted that there is a third party involved who plays the game with ease, apart from the intermediary and policyholders. They are called "NEXUS" in fraud and industry terms (Viaene et al, 2004).

Types of Insurance Fraud

The Insurance Regulatory and Development Authority of India (IRDAI) defines 3 generalized classifications for insurance fraud in India:

• Claims/Policyholder/Customer Fraud- This includes fraud against the insurance company during the purchase, execution, or claims processing of an insurance product or policy.

a) Exaggerating losses/damages

b) Staging un- occurred incidents

c) Falsely reporting and claiming damage/loss

d) False Medical Claims

e) False Death Claims

•Intermediary Fraud- If an Insurance Agent/ Third Party Administrator Agents (TPA)/Corporate Agent or any intermediary perpetrates any fraud against the policyholders, customers, or the insurance company.

a) Premium diversion- The premium is collected from the buyer but not passed on to the insurer via the intermediary.

b) The premium is inflated and after paying the correct amount to the insurer the agents keep the difference with them.

c) Failure to misrepresent or disclose the risk for lower premiums

d) Commission fraud - Trying to ensure non-existent policyholders by paying the initial premium, receiving a commission, and cancelling the insurance by discontinuing premium payments.

• Internal Fraud- If a director, manager, or officer in the higher ranks indulges in misappropriation or fraud against the insurance company.

a) Embezzlement of funds

b) Falsified financial reports

c) Cheque forgery

d) Circumventing denial decisions with the aim of registering accounts for relatives and friends

e) Inflating expenses, claims/overbilling

f) Paying fake (or inflated) invoices, whether made by the company or obtained through collaboration with suppliers

g) Offering special privileges to customers in exchange for kickbacks or favours, or granting business to preferred suppliers

h) Falsification of signatures

i) Taking money out of customers' accounts

j) Faked documents

k) Selling assets of insurers for less than their actual worth in exchange for cash.

Out of the three frauds defined by IRDAI, claims fraud is the most common, and they are divided into Hard Fraud and Soft Fraud:

I. Hard fraud: If an individual deliberately invents loss such as theft, destruction of property (like arson), or self-inflicted injury to claim benefits from respective policies.
II. Soft Fraud: Opportunistic or Soft fraud includes exaggerated claims by policyholders. The actual damages are not disclosed and a hyperbolic representation of the situation isgiven.

Different Types of Health Insurance Frauds: Perspective of Shriram Health Insurance

The health insurance market is rising and being shouted about like a new mantra, yet India is still losing money in this area due to the ever-increasing fraud claims. They are discussed as under:

I. "Opportunity Fraud" – Opportunity fraud refers to any information that is incorrect or misleading. It is usually done by a customer to verify that the underwriting is favourable to them.

II. "Deliberate Fraud" – In this case, an accident/loss covered in the policy is reported on purpose in order to obtain the benefit.

III. "External Fraud" – This sort of fraud is perpetrated by vendors, policyholders, beneficiaries, and even against a corporation.

IV. "Internal Fraud" – Employees like agents, managers, and executives commit this kind of fraud against a firm or a policyholder.

V. "Policyholder's Fraud" - Nowadays, consumers are aware of the norms, characteristics, and rules of insurance and have begun to benefit from it by being involved in fraud. There are three types of policyholder fraud: application fraud, eligibility fraud, and claim fraud.

- "Eligibility fraud"- This scam often involves the misrepresentation of details given about the insured's job status, pre-existing conditions, or dependent information. In this case, the beneficiary obtains benefits in an illegal manner, such as when a person files a claim for a dependant or a relative, who is not covered by the insurance. Another example is when a part-time worker is not covered under a company-provided health plan for full-time employees, but by creating fraudulent documents with any HR employee, he is able to receive the benefits.
- "Application fraud"- It is commonly perpetrated in the health insurance business when a consumer deliberately inserts fabricated information in his or her application relating to pre-existing diseases, claims, or crucial dates. For example, a policyholder may choose not to include information about diseases or serious medical problems which were there from before in order to obtain comprehensive coverage and hassle-free claim filing. Even at some times, the employer manipulates the employee's start date by obtaining approval from the insurance provider.
- "Claim fraud" - Claim fraud takes place when a customer files an unauthorized claim for a benefit to which he is not entitled. Commonly, in the case of maternity benefits, fake claims could be requested. In such circumstances, the member and provider are shown to collide, so benefiting the physician. Such organizations are often called fraud rings. Another scenario is that a policyholder may resort to insurance speculation, in which he acquires multiple health insurance plans without informing the insurance providers and receives claim payment from all of them. Furthermore, hospital agents generate larger medical expenses connected to hospitalization, therapy, and so forth in order to fill their pockets.

Common Frauds by a Health Insurance Customer

• Hiding pre-existing illness (PED) / chronic condition, tampering with pre-policy health check-up results

• Fabricated/ Falsified documents in pursuance of meeting policy criteria and conditions

• Bills that are duplicated or exaggerated

• Obtaining several insurances, being part of fraud rings,

• Fabricated accidents and disability claims

Common Frauds Committed by Agents & Brokers

• providing bogus policies to customers and siphoning off premiums;

• tampering with pre-policy health check-up reports

• advising consumers to conceal PED/material information in order to receive coverage or file a claim,

• taking part in fraud networks and facilitating insurance under bogus identities

• directing customers to rogue providers

• falsifying information in group health insurance

Common Frauds committed by Providers

• Overcharging, inflated billing, and invoicing for services not rendered •

• Unnecessary surgeries, extensive investigations, and costly medications

• Upcoding & Unbundling

• Excessive use, prolonged length of stay

• falsifying records, falsifying patient history

The Concept of Fraud Diamond

The Fraud Triangle is a metaphor for why someone decides to commit fraud which is frequently used in auditing. It has been around for a while and can help any organization or company to understand the numerous routes via which fraud might be initiated. Before incorporating controls and procedures into the fraud diamond, one would want to consider how implementing controls and procedures can increase an organization's resilience when it comes to controlling fraud. The Fraud Triangle asserts that there are three components that contribute to the growth of the risk of fraud: (1) incentive, (2) opportunity, and (3) rationalization.

For fraud to happen, firstly, external motivation is required. It can be in terms of target pressure on agents, having monetary gains, or any kind of higher achievement. It is required to have rationalization of the desired action after the motivation factor, where the person believes that violation of rules is acceptable and a small fraud won't influence anyone drastically and the prospective fraudster thinks that he or she deserves the fraud amount and has accomplished it. Then, people start looking for an opportunity to commit fraud. He/she starts looking for gaps in the system or process where no one will be looking and fraud can be conducted easily. The person then uses his/her experience in the field of his/her position and tries to manipulate othersor exploit the system's weakness to commit fraud.

1. Fraud Triangle – Opportunity

The word "opportunity" denotes the circumstances that lead to fraud. It's the only part of the fraud triangle that a company can completely manage. The following are some examples of scenarios that could lead to fraud:

Weak internal controls

Internal controls are systems and procedures in place to ensure that accounting and financial data is accurate. Internal controls that are weak, such as poor role separation, insufficient monitoring, and insufficient process documentation, increase the risk of fraud.

Poor tone at the top

The tone at the top refers to top management and the board of directors' commitment to being ethical, honest, and transparent; a bad tone at the top makes a company more vulnerable to fraud.

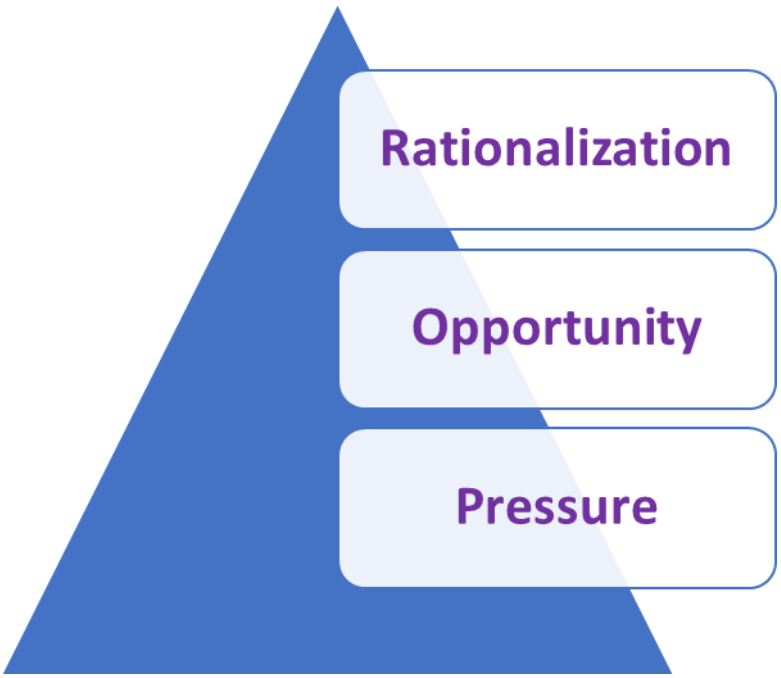
Inadequate accounting policies

The documentation of financial statement items is governed by accounting policies. If accounting procedures are lax, employees can manipulate figures (inadequate).

2. The Fraud Triangle – Incentive

The term incentive, which is sometimes known as pressure, refers to an employee's willingness to commit fraud. Here are a few examples of factors that encourage people to commit fraud.

Fig.1 Fraud Triangle:



(Source: www.google.com)

Incentives depending on the financial metrics

Revenues and net income are two key financial indicators used to assess an employee's success. Employees who receive bonuses based on financial indicators are under pressure to meet targets, which motivates them to commit fraud to achieve the target.

Analyst and investor expectations

The pressure on a company to meet or exceed analyst/ investor standards, and to maintain or improve stock prices can lead to fraud.

Incentives for individuals

Personal motivators could include a desire to earn more, the need to pay monthly payments, or gambling addictions, along with many other things.

3. The Fraud Triangle – Rationalization

Rationalization is a person's justification for defrauding others. The following are some examples of common rationalizations made by fraudsters:

“They treated me wrong”

A person may be unhappy with their management or supervisors and believe that defrauding them is the best way to get even.

“Upper management is doing it as well”

A negative tone from the top may cause the person to follow in the footsteps of others higher up the corporate ladder.

“There is no other solution”

Some people believe that if they don't commit fraud, they'll lose everything they own (for example, their job).

Obstacles to Combating Insurance Fraud

One of the most significant barriers to preventing insurance fraud is that most governments throughout the world don't really consider insurance fraud to be a crime. This entails that disclosing insurance fraud to a cop is usually fruitless since our law system lacks the protocols to handle insurance fraud. It's no surprise, then, that our global Insurance fraud detection industry has been steadily growing, accounting for over USD 4.1 billion in 2018 (As per the Report of Grand View Research. Please see ‘References’ to access the Report).

Even in India, it is a matter of concern “that insurance fraud is not defined under the Indian Insurance Act”. Recently, IRDA cited the definition of the International Association of Insurance Supervisors (IAIS), which defines fraud as "*an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties*." Other equipments of the law of "Indian legal system", like, the Indian Contract Act or the Indian Penal Code (IPC), do not provide particular laws either. Sections of the IPC dealing with

fraudulent acts, forgery, and deceit, and so on are sometimes applied, although none of them are expressly aimed at fraud in insurance and are ineffective as a deterrent.

A few sections are given alongside which may be admissible: "Section 205-false impression for the purpose of Act or proceeding in persecution or suit; Section 420-deceiving and dishonestly inducing delivery of the property; Section 464-making a false document including signs, seals, and forgery and Section 405-criminal breach of trust." However, in the current environment of organized insurance fraud, these rules are insufficient to punish a fraudster lawfully.

Due to the growing backlog of outstanding judicial cases in our courts, initiating legal action over insurance frauds is uncommon, and frauds of small enough sums are often dismissed rather than putting in the time and effort to follow them.

Impact of Fraud

• Underwriting - The impact of claims fraud on underwriting rules & policies, and the overall risk pool, cannot be overstated.

•Social Cost: As a result of claim fraud, insurance prices rise overall.

• Unfair to the rightfully worthy: Claim fraud causes even the most eligible claimants to be denied or need to give further proof on a claim.

• Undetected fraud fosters further fraud: Whenever a successful fraud is performed, individuals are more likely to engage in additional fraud, encouraging more fraud.

• Loss of Credibility: The recurrence of bogus claims in an insurance firm leads to a loss of market attractiveness, which reduces competitiveness.

• Customer relationship: Bogus claims have a negative impact on insurers' relationships with both current and prospective customers.

• Regulatory Requirements: Recurrent frauds, or maybe even a few serious frauds, can land an insurer in serious legal trouble with regulators.

• Lack of faith: As a consequence of fraud cases, people's belief in insurance is eroding, which is detrimental to the growth of the insurance sector.

Insurance Fraud Monitoring Framework as per IRDAI

Insurance fraud undermines customers' and shareholders' confidence and can harm the credibility of individual insurers as well as the insurance industry as a whole. It may also have an impact on economic stability. As a result, insurers must try to understand the nature of the fraudulent activity and take efforts to reduce the exposure of their operations to fraud. The Authority has prescribed a number of actions to be done by insurance companies to mitigate the numerous risks they face under the "Regulatory Framework" put in place. Some of these are:

•According to the Corporate Governance standards, insurance companies must form a Risk Management Committee (RMC). The RMC is responsible for developing the company-wide Risk Management Strategy.

•On an annual basis, the management of an insurance company is obliged to reveal the adequacy of systems in place to safeguard the assets for preventing and detecting fraud and other irregularities as part of the "Responsibility Statement" that forms part of the "Management Report" filed with the Authority under the IRDA (Preparation of Financial Statements and Auditors' Report of Insurance Companies) Regulations, 2002.

The Authority has established guidelines mandating insurance providers to have in action the Fraud Monitoring Framework in order to provide regulatory supervision and advice on the sufficiency of steps undertaken by insurers to address and manage risks emanating from fraud.

Anti-Fraud Policy:

All insurance businesses are expected to have an Anti-Fraud Policy in place that has been authorized by their separate boards. "The Policy shall duly recognize the principle of proportionality and reflect the nature, scale, and complexity of the business of specific insurers and risks to which they are exposed." The insurance company should take into account all relevant factors while developing the policy, including but not limited to the organizational structure, insurance products offered, the technology used, market conditions, and so on. Because fraud can be committed through a collaboration involving multiple parties, insurers should take a comprehensive strategy to appropriately identify, measure, control, and monitor fraud risk and, as a result, implement appropriate risk management policies and procedures throughout the business.

The Board shall evaluate the Anti-Fraud Policy at least once a year and at such other times as may be deemed necessary.

The anti-fraud policy as per IRDAI shall broadly cover the following aspects (India, Insurance Regulatory and Development Authority, Ministry of Finance, 2013):

I. Procedures for Fraud Monitoring:

Well-defined procedures should be laid down to detect, identify, report and investigate insurance fraud. The function of fraud monitoring shall be either an independent function or can be merged with existing functions like audit, risk, etc., The Head of this function should be placed at a sufficiently senior management level and should be able to operate independently.

II. Identify Potential Areas of Fraud:

To identify such areas of business and the specific departments of the organization that are potentially susceptible to insurance fraud and lay down detailed anti-fraud procedures separately for each department. These procedures should lay down the framework for the prevention and identification of fraud and mitigation measures.

III. Co-ordination with Law Enforcement Agencies:

Such procedures should be laid down so as to coordinate with law enforcement agencies for reporting frauds on a timely and prompt basis and follow-up processes right away.

IV. Framework for Exchange of Information:

Such procedures should be laid down for the exchange of necessary information on frauds, among all insurers through the Life and General respective councils. The insurance companies are well- advised to establish coordination platforms through their respective Councils and/or forums to establish such information-sharing mechanisms.

V. Due Diligence:

Such procedures should be laid down so as to carry out the due diligence on the personnel (staff and management)/ insurance agent/ Corporate Agent/ intermediary/ TPAs before appointment/ agreements with them.

VI. Regular Communication Channels:

Fraud mitigation communication should be generated within the organization at periodic intervals and/or Ad hoc basis, as may be required, and lay down the appropriate framework for a strong whistle-blower policy. The insurer shall also formalize the information flow amongst the various operating departments as regards insurance fraud.

Fraud Monitoring Function (FMF):

The FMF shall take care of the effective implementation of the anti-fraud policy of the company and shall also perform the following functions:

i. Formulating procedures for Internal reporting to and/ from various departments.
ii. Creating awareness among their employees/ intermediaries/ policyholders to counter insurance fraud.
iii. Furnishing various reports on frauds to the Authority as stipulated in this regard; and
iv. Provide periodic reports to their respective Board for feedback

Reports to the Authority:

"The statistics on various fraudulent cases which come to light and action taken thereon shall be filed with the Authority informs FMR 1 and FMR 2 providing details of:

(i) Outstanding fraud cases; and

(ii) Closed fraud cases

Each year, within 30 days of the end of the financial year,

the preventive mechanism as stated by IRDAI:

"The Insurer shall inform both potential clients and existing clients about their anti-fraud policies. The Insurer shall appropriately include necessary caution in the insurance contracts/ relevant documents, duly highlighting the consequences of submitting a false statement and/or incomplete statement, for the benefit of the policyholders, claimants, and the beneficiaries."

• IRDA Fraud Policy:

According to the Insurance Regulatory and Development Authority, each insurance company is required to develop a Fraud Monitoring Framework (IRDA). The framework must include provisions to protect, deter, identify, and reduce the risk of fraud from insurance company policyholders/claimants, intermediaries, and employees.

• Anti-Fraud policies:

Insurers are expected to take a comprehensive approach to accurately define, assess, track, and monitor fraud risk and, ultimately, develop effective risk management policies and procedures. According to IRDA, the boards of directors of insurance companies are required to review their respective anti-fraud policies on an annual basis, as well as at any other intervals deemed appropriate. These policies must provide detailed guidance on fraud detection protocols, recognizing possible fraud routes, and recommendations for partnering and working with state and local enforcement authorities to recognize both the act of fraud and the perpetrators."

• Fraud Monitoring Function:

Each insurance provider requires the Fraud Monitoring Function as a separate vertical to ensure the successful enforcement of anti-fraud policies. They are in charge of developing internal reporting processes from/to various departments in order to inform staff, intermediaries, and policyholders about fraud detection and prevention. In addition, they will notify regulatory authorities on a regular basis about these occurrences as well as the steps taken within a specific time frame to avoid these scenarios. They must eventually submit annual reports to their respective boards for review and correction of the courses. (Source: IRDAI)"

McKinsey's Framework for Systematic Optimization of Fraud:

McKinsey has designed a framework that permits the systemic optimization of fraud detection and prevention while working with multiple insurers on an industry-wide scale. This methodology is based on a clearly stated fraud strategy (zero tolerance for any confirmed fraud, for example, to safeguard honest customers) and employs seven levers, both for core fraud management activities (detection, investigation, and prevention) and the corresponding support systems.

The following examples demonstrate the steps that an insurer can take to improve their Fraud Management:

- Improve detection: Checklist/ fraud manuals assist claims managers in manually identifying questionable claims instances. Experimentation has shown that the approach can greatly boost detection rates while requiring no IT expenditure. Even within the same organization, claims handlers have varying levels of expertise and success in identifying situations where fraud is anticipated. A systematic checklist/ fraud manual can help groups learn from one another and achieve a more homogeneous and better detection rate overall.
- Implement a triage function: The goal here is to develop a phased fraud management process in which triage (first case evaluation and resource allocation decision) serves as the core decision-making point. The function determines whether an inquiry into an

instance, where fraud is suspected, should be conducted using the applicable fraud approach and (typically) a cost-benefit analysis. In addition to this, the triage specialist is responsible for three other responsibilities. The first step is to collect information on the cases and allocate them to fraud specialists who are ready to investigate them, based on their segmentation/specialization and current workload. Second, the triage specialist is in charge of continually optimizing fraud detection using info 5 and mentoring claims handlers. During this process, he or she also ensures that the criteria and indications of any existent IT-supported recognition are continually improved. Third, he/she is accountable for the KPI-based monitoring of fraud management progress utilizing case data and savings realized along the fraud funnel.

- Employ extensive inquiry procedures: Cognitive interviews, for example, could be used to measure the interviewee's honesty. This entails examining the consistency of responses to changing or recurrent questions on the same topic. The judgment also takes into account the recall of detail and the vivacity of the description.
- Fraud management must be prioritized at the highest levels of management: Optimizing fraud management necessitates a strong commitment from the board to address this issue and to undertake the necessary culture change at the company outside the claims department.
- Describe fraud and how to deal with it clearly: The fraud plan should clearly establish the company's definition of fraud as well as the repercussions it is willing to endure. After all, the problem of fraud control extends well beyond claims organization to include sales and operations. As a result, it is critical to reach an agreement on the plan with the concerned departments. When and how would a case be classified as fraudulent? No more kindness should be extended after which point? When is it appropriate to terminate a contract and when is it appropriate to submit a police report? These standards must be consistently and clearly stated, both within and to customers.
- Rather than making large IT investments right away, start by establishing processes, KPIs, and roles: In general, IT adds significant value to fraud management, notably in the identification of fraud. However, it should be based on well-defined processes and KPIs and should not be on a critical chain. Waiting till IT solutions are available to begin optimizing fraud control is not technically nor economically prudent, because so many manual efforts initially require little or no IT support. As a result, it is frequently beneficial to first build or optimize the processes, KPIs, and roles, and use these to determine the IT system needs.
- Pilot early and in tandem with design: The new technique should preferably be evaluated early on, alongside fine-tuning the concept in a pilot project. This simultaneous testing of novel ways can provide significant business experience for future fraud prevention and detection in an iterative procedure that can be easily included in concept refinement.
- Expand the number of fraud specialists and their skills/specializations: Fraud management has enormous economic potential, but it can only be realized if significant expenditures are made in developing skills and recruiting enough fraud professionals. The emphasis should be on efficacy rather than solely on efficiency.
- Strive for constant development: Fraud management is a continually evolving topic. Scammers, who are frequently extremely professional, quickly alter their approach.

- Insurers' behaviour. Companies must respond to this by upgrading their full procedure to guarantee that they will be equally quick to react, from detecting and investigating fraud to disciplining individuals implicated. A significant aspect of this is the regular interchange of feedback and recognition of changes amongst triage and fraud experts and also claims handlers.
- Extend optimization outside the claims division: Improving fraud management is mostly, but not completely, the responsibility of the claims division. This should be integrated with Underwriting/Products, Operations, and Sales in order to implement stringent fraud prevention and overall consequence management (including the termination of contracts)."

Conclusion

There is awareness amongst insurance companies about the existence of health insurance fraud (Villegas-Ortega et al., 2021) and that the problem has to be resolved through whatever means within the regulatory framework. The insurers have their internal mechanisms and systems for the detection of fraud and investigation units but somehow there seems to be a tolerant attitude towards insurance fraud either due to the complexity of the problem or the costs involved.

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